DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/11/14

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the corridor openings. The finding included: On 8/25/14 at 11:35 AM observation within the West hall area revealed the nourishment room door had a one-inch (1") diameter through penetration in the locking area. National Fire Protection Association (NFPA) 80; 101; 8.2.3.2.4; 101, 19.3.6.3.1 This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit conference on 8/25/14.	K 027	Nourishment room door penetration has been repaired. All other facility doors have been checked for compliance. Door penetrations will be added to the facilities weekly compliance rounds. The Maintenance Director will be responsible for monitoring compliance. Compliance will be supported by evidence of weekly compliance rounds. Audits of these rounds will be reported to the Quality Assurance Process Improvement Committee for three months to ensure compliance.	9-16-14
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by:	K 147		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kerry B. Cofer — TITLE: Administrator — (X6) DATE: 9/18/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	445180	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/25/2014

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MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

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K 147	Continued From page 1 Based on testing and observation, it was determined the facility failed to maintain the electrical equipment. The findings included: On 8/25/14 at 1:50 PM testing of the Ground Fault Circuit Interrupters in resident rooms 101, 103, 106, 108, and 206 next to sinks revealed the units were not connected as GFCI units. NFPA 70, 210-8(a)(7) These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit conference on 8/25/14.	K 147	Rooms 101,103,106,108 and 206 have GFCI units connected now per NFPA 70,210-8(a)(7) All other resident rooms have been checked for compliance. Maintenance Director will monitor for continued compliance through weekly rounds. Audits of these compliance rounds will be reported to Quality Assurance Process Improvement Committee on a monthly basis for 3 months. Any non-compliance will require a plan of correction and be reported to the Quality Assurance Process Improvement Committee for further monitoring to ensure compliance.	9-16-14